State of Connecticut
Office of Health Care Access
Letter of Intent/ Waiver Form (2030)

All applicants must complete a Letter of Intent (LOI) form prior to submitting a Certificate of Need application, pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes and Section 19a-160-64a of OHCA's Regulations. Applicants should submit this form to the Commissioner of the Office of Health Care Access, 410 Capitol Avenue, MS# 13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. APPLICANT INFORMATION

If more than two Applicants, please attach a separate sheet of paper and provide additional information in the format below.

	Applicant One	Applicant Two
Full legal name	LMG Programs, INC	
DBA (Doing Business As)	n/a	
Name of Parent Corporation	n/a	
Mailing Address, if Post Office Box, include a street mailing address for Certified Mail	159 Colonial Rd Stamford, CT 06906	
Applicant type (e.g., profit/ non-profit)	Non-Profit	
Contact person, including title or position	Cary Ostrow VP of Quality Systems	
Contact person's street mailing address	Same as above	
Contact person's phone #, fax # and e-mail address	203-325-1511, F:203-325-4936 cary.ostrow@lmgprograms.org	

SECTION II. GENERAL APPLICATION INFORMATION

Proposal/Project Title: **Termination of Meridian Hill Detox**

Type of Proposal, please check all that apply:

☐ Change in Facility (F), Service (S) or Function (Fnc) pursuant to Section 19a-638, C.G.S.

☐ New (F, S, Fnc)	☐ Replacement	☐ Additional (F, S, Fnc)
☐ Expansion (F, S, Fnc)	☐ Relocation	☒ Service Termination
☐ Bed Addition	☐ Bed Reduction	☐ Change in Ownership or Control

☐ Capital Expenditure pursuant to Section 19a-639, C.G.S.
- ☐ Project cost greater than $ 1,000,000
- ☐ Equipment Acquisition greater than $ 400,000
  - ☐ New ☐ Replacement ☐ Major Medical
  - ☐ Imaging ☐ Linear Accelerator
- ☐ Change in ownership or control, pursuant to Section 19a-639 C.G.S., resulting in a capital expenditure over $1,000,000

Location of proposal (Town including street address): 4 Elmcrest Terrace, Norwalk, CT 06850

List all the municipalities this project is intended to serve: Lower Fairfield County

Estimated starting date for the project: July 1st, 2005

Type of Entity: (Please check E for Existing and P for Proposed in all boxes that apply)

E	P		E	P		E	P	
☐	☐	Acute Care Hospital	☐	☐	Imaging Center	☐	☐	Cancer Center
☒	☐	Behavioral Health Provider	☐	☐	Ambulatory Surgery Center	☐	☐	Primary Care Clinic
☐	☐	Other (specify): (E)_____			(P)_____			

Type of project: _____ **(Fill in the appropriate number(s) from page 4 of this form)**

Number of Beds (to be completed if changes are propsed)

Type	Existing Staffed	Existing Licensed	Proposed Increase (Decrease)	Proposed Total Licensed
4o	28	28	(28)	0

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

Estimated Total Capital Expenditure: $0

Please provide the following breakdown as appropriate:

Renovations	$
New Construction	$
Fixed Equipment	$
Movable Equipment	$
Fair Market Value of Leased Space	$
Fair Market Value of Leased Equipment	$
Other	$

Note: The aggregate of all categories should equal the estimated total capital expenditure.
"Other" includes any category not listed above, (e.g., land acquisition, service agreement, fees, etc.)

Major Medical equipment acquisition:

Unit Type	Model	Name	Number of Units	Cost

Type of financing or funding source (more than one can be checked):

☐ Applicant's Equity ☐ Lease Financing ☐ Conventional Loan
☐ Charitable Contributions ☐ CHEFA ☐ Grant Funding
☐ Other (specify): _____

SECTION IV. PROJECT DESCRIPTION

Please attach a separate 8.5" X 11" sheet(s) of paper and provide no more than a 2 page description of the proposed project, highlighting all the important aspects of the proposed project. Please be sure to address the following:

1. What are the anticipated payer sources?
2. Identify any unmet need and how this project will fulfill that need.
3. What is the effect of this project on the health care delivery system in the State of Connecticut?
4. Are there any similar existing providers in the proposed geographic area?
5. Why should this project be approved?
6. Who will be responsible for providing the service?
7. Who is the target population?

If requesting a Waiver of a Certificate of Need, please complete Section V.

SECTION V. WAIVER INFORMATION

I may be eligible for a waiver from the Certificate of Need process because of the following: (Please check all that apply)

☐ This request is for Replacement Equipment
- ☐ The original equipment was authorized by the Commission/OHCA in Docket Number: _____
- ☐ The cost of the equipment is not to exceed $2,000,000
- ☐ The cost of the replacement equipment does not exceed the original cost increased by 10% per year.

Please complete the attached affidavit.

For Office Use Only:

Action taken:

☐ Waiver Approved ☐ Waiver Denied
☐ Appropriate Forms Sent List of the forms sent: _____

LMG

Saving Lives from Drugs and Alcohol

TERMINATION OF SERVICES FOR THE MERIDIAN HILL DETOX PROGRAM

Section IV

1. What are the anticipated payer sources?

   N/A

2. Identify any unmet need and how this project will fulfill that need.

   N/A

3. What is the effect of this project on the health care delivery system in the State of Connecticut?

   Meridian Hill is a 28 bed residential detoxification program, located in Norwalk. LMG does not believe that this treatment option is the best choice for the clients it serves for the following reasons:

   - Medically monitored detox beds have decreased in this region from 56 to 38 beds in the last two years and yet Meridian Hill still cannot maintain a workable census. Demand is low and shrinking.
   - The overwhelming majority of the clients served are opiate dependent individuals who do not medically require a residential detox program. Ambulatory methadone detox or methadone maintenance are better options, with better outcomes.
   - Clients are increasingly coming from outside the region. This makes it very difficult to make appropriate referrals, connect clients with a supportive environment (either family or social supports) upon discharge and defeats the purpose of community-based treatment
   - The success of DMHAS' OATP program means a lower demand for residential services and an increased demand for ambulatory meth detox or meth maintenance
   - It is increasingly difficult to find and keep nursing staff. The constant juggling and usage of nursing temps has led to minimal consistency, increased time in training and poorer client outcomes
   - More restrictive admission criteria has limited the number of clients who can enter this form of treatment

4. Are there any similar existing providers in the proposed geographic area?

    - Residential detox beds are dwindling because agencies cannot support a service that has poor outcomes and at a high financial cost
    - Methadone maintenance and ambulatory detox programs (which have better outcomes) are available in the three major towns LMG serves: Stamford, Norwalk and Bridgeport
    - DMHAS maintains a residential detox program in Bridgeport, the largest source of LMG's clients
    - Hall-Brooke provides inpatient treatment for acute psychiatric conditions, medical detoxification for persons who are chemically dependent, as well as a specialized program for individuals with co-existing psychiatric and substance abuse disorders

5. Why should this project be approved?

    - Clients from our catchment area will be better served in one of the available methadone maintenance or ambulatory detox programs, or finding suitable programs in a region closer to their home
    - Given the lack of medical necessity for the service and the high cost, the state dollars supporting this service would be better spent in methadone and ambulatory detoxification programs

6. Who will be responsible for providing the service?

    - N/A

7. Who is the target population?

    - N/A

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

April 27, 2005

Cary Ostrow
Vice President of Quality Systems
LMG Programs, Inc.
159 Colonial Road
Stamford, CT 06906

RE: Certificate of Need Application Forms, Docket Number 05-30488-CON
LMG Programs, Inc.
Terminate Residential Detox Program in Norwalk

Dear Mr. Ostrow:

Enclosed are the application forms for LMG Programs, Inc.'s Certificate of Need ("CON") proposal for the Terminate Residential Detox Program with no associated capital expenditure. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes the CON application may be filed between June 20, 2005, and August 19, 2005.

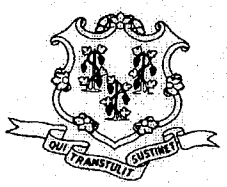
When submitting your CON Application, please paginate and date each page contained in your submission. In addition, please submit one (1) original and five hard copies; as well as a scanned copy of the complete Application, including all attachments, on CD or Diskette. OHCA requests that the electronic copy be in Adobe or MS Word format and that the Financial Attachment and other data as appropriate be in MS Excel format.

The analyst assigned to the CON application is Laurie Greci. Please feel free to contact him/her at (860) 418-7001, if you have any questions.

Sincerely,

Kimberly Martone
Certificate of Need Supervisor

Enclosures



State of Connecticut
Office of Health Care Access
Certificate of Need Application

Please complete all questions. If any question is not relevant to your project *Not Applicable* may be an acceptable response. Your Certificate of Need application will be eligible for submission no earlier than June 20, 2005, and may be submitted no later than August 19, 2005. The Analyst assigned to your application is Laurie Greci and may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number: 05-30488-CON

Applicant(s) Name: LMG Programs, Inc.

Contact Person: Cary Ostrow
Contact Title: Vice President of Quality Systems
LMG Programs, Inc.
Contact Address: 159 Colonial Road
Stamford, CT 06906

Project Location: Norwalk

Project Name: Terminate Residential Detox Program

Type proposal: Section 19a-638, C.G.S.

Est. Capital Expenditure: $ 0

1. **State Health Plan**

   No questions at this time.

2. **Applicant's Long Range Plan**

   Is this application consistent with your long-range plan?

   ☐ Yes ☐ No

   If "No" is checked, please provide an explanation.

3. **Clear Public Need and Impact on Accessibility**

A. List the behavioral health services currently offered by LMG Programs, Inc. Identify the location of each service.

B. Regarding this termination of services, please answer the following:

   i) Provide a complete discussion as to the Applicant is proposing to terminate the residential detox program in Norwalk. Include in detail the rationale for the proposal to terminate the service.

   ii) Identify the process undertaken by the Applicant in making the decision to terminate.

   iii) Discuss the past and current demand for the program. Include in the discussion changes in the level of need, changes in treatment protocols, and any other factors that have affected the demand for the service.

   iv) What alternatives, such as decreasing the number of beds, were considered other than termination of the service? Discuss the reasons why such alternatives were not implemented.

   v) Has the Applicant been receiving reimbursement by third party payers? Discuss the reimbursement levels prior to the determination to terminate the service. How did the reimbursement levels enter into the determination to terminate?

   vi) Did this termination require the vote of the Board of Directors of the Applicant? If so, please provide a copy of the minutes (excerpted for other unrelated business) for the meeting(s) at which this termination was discussed and voted on. Provide a copy of the Board of Directors' resolution(s) approving the proposal.

C. Identify the primary and secondary service area towns for the service.

D. Provide the following utilization statistics for the past three fiscal or calendar years:

i) The number of admissions by patient's town of origin.
ii) Average length of stay.

E. Discuss any waiting list or scheduling backlogs that existed at the time of the decision to terminate the service. How many patients were on the waiting list?

F. Describe the pattern of referrals for the service during the past three fiscal or calendar years.

4. Impact on the Patient and Provider Community

A. Explain in detail the procedures that the Applicant will follow to terminate the service and discharge patients. Include in the discussion the transferal of patients to other providers.

B. Discuss how patients still requiring the level of service proposed for termination will receive care. List any special populations that were utilizing the service and explain how these patients will have continued access to care.

C. Provide the information as outlined in the following table concerning the existing providers' of the service proposed for termination in your primary and secondary service areas:

Description of Service	Provider Name and Location	Hours and Days of Operation[1]	Current Utilization[2]

[1] Specify days of the week and start and end time for each day, if applicable.
[2] Number of clients served by Provider for the most recent 12 month period, if known.

D. Has your facility contacted any other providers to determinate their ability to absorb the patient population base for displaced patients? Please provide a detailed explanation, including any written agreements or memorandum of understanding between the Applicant and any other facilities as related to the proposal.

E. What affect will the termination of the service have on existing providers (i.e. patient volume, financial stability, quality of care, etc.)?

F. Will the termination of the service create any barriers to access in the region? Please discuss.

G. Provide information and supporting documentation addressing the issue of transportation. Does the Applicant currently provide transportation for its patients? Describe how patients would be able to travel to a new service location without benefit of a personal vehicle.

H. How will your proposal impact any of the following barriers to access? Please provide an explanation.

☐ Cultural ☐ Transportation

☐ Geographic ☐ Economic

☐ None of the above ☐ Other (Identify) _____

If you checked other than None of the above, please provide an explanation.

I. Provide copies of any of the following plans, studies or reports specifically related to your proposal:

☐ Epidemiological studies ☐ Needs assessments

☐ Public information reports ☐ Market share analysis

☐ Other (Identify) _____

5. Quality Measures

A. Provide or answer the following:

i) Provide copies of any Department of Public Health Quarterly Action Reports, Consent Decrees or Statement of Charges against the Applicant, Physicians and any staff related to the proposal, for the past five (5) years.

ii) Provide a copy of the State of Connecticut Department of Public Health license(s) currently held by LMG Programs, Inc.

i) Are there any unique characteristics of your patient/physician mix?

☐ Yes ☐ No

If you checked "Yes," please provide an explanation.

ii) Submit a list of all key professional and administrative personnel, including the Applicant's Chief Executive Officer (CEO) and Chief Financial Officer (CFO), related to the proposal and a copy of their Curriculum Vitae.

Note: For physicians, please provide a list of hospitals where the physicians have admitting privileges.

iii) Provide a copy of the following (as applicable):

☐ A copy of the related Quality Assurance plan

☐ Patient Selection Criteria/Intake form

iv) Provide a copy of the most recent inspection reports and/or certificate for your facility:

☐ DPH ☐ JCAHO

☐ Fire Marshall Report ☐ Other States Health Dept. Reports (new out-of-state providers)

☐ AAAHC ☐ AAAASF

☐ Other: _____

Note: Above referenced acronyms are defined below. [1]

6. Improvements to Productivity and Containment of Costs

In the past year has your facility undertaken any of the following activities to improve productivity and contain costs?

☐ Energy conservation ☐ Group purchasing

☐ Reengineering ☐ None of the above

☐ Application of technology (e.g., computer systems, robotics, telecommunication systems, etc.)

☐ Other (identify)_____

7. Miscellaneous

A. Please describe the impact of the proposal on the interests of consumers of health care services and the payers of such services.

B. Will this proposal result in a change to your teaching or research responsibilities?

☐ Yes ☐ No

If you checked "Yes," please provide an explanation.

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[1] DPH – Department of Public Health; JCAHO – Joint Commission on Accreditation of Hospitals Organization; AAAHC – Accreditation Association for Ambulatory Health Care, AAAASF – American Association for Ambulatory Surgery Facilities, Inc.

8. Financial Information

A. Type of ownership: (Please check off all that apply)

☐ Corporation (Inc.) ☐ Limited Liability Company (LLC)

☐ Partnership ☐ Professional Corporation (PC)

☐ Joint Venture ☐ Other (Specify): _____

B. Does the Applicant(s) have Tax Exempt Status? ☐ Yes ☐ No

C. Verify that this termination of services has not resulted in any capital expenditures or capital costs to the Applicant.

9. Revenue, Expense and Volume Projections

A) Provide the following financial information:

i) Please submit an audited or unaudited Balance Sheet and Income Statement or Statement of Operations for the two most recently completed fiscal years. These statements should be externally prepared and submitted on the preparer's letterhead.

ii) Provide a discussion of any incremental gains or losses from operations that will result from the termination of the service.

B) Please provide the current payer mix for LMG Programs, Inc. based on Net Patient Revenue in the following reporting format:

	Provider's Payer Mix
Medicare*	
Medicaid* (includes other medical assistance)	
TriCare (CHAMPUS)	
Total Government Payers	
Commercial Insurers*	
Self-Pay	
Workers Compensation	
Total Non-Government Payers	
Uncompensated Care	
Total Payer Mix	100.0%

*Includes managed care activity.

OFFICE OF HEALTH CARE ACCESS

REQUEST FOR NEW CERTIFICATE OF NEED

FILING FEE COMPUTATION SCHEDULE

APPLICANT: _____	FOR OHCA USE ONLY:		
PROJECT TITLE: _____		DATE	INITIAL
DATE: _____	1. Check logged (Front desk)	_____	_____
	2. Check rec'd (Clerical/Cert.)	_____	_____
	3. Check correct (Superv.)	_____	_____
	4. Check logged (Clerical/Cert).)	_____	_____

SECTION A – NEW CERTIFICATE OF NEED APPLICATION	
1. Check statute reference as applicable to CON application (see statute for detail):	
_____ 19a-638.Additional function or service, Change of Ownership, Service Termination. **No Fee Required.**	
_____ 19a-639 Capital expenditure for major medical equipment, imaging equipment or linear accelerator exceeding $400,000 but less than or equal to $1,000,000. **Fee Required.**	
_____ 19a-639 Capital expenditure for major medical equipment, imaging equipment or linear accelerator exceeding $1,000,000 or other capital expenditure exceeding $1,000,000. **Fee Required.**	
_____ 19a-638 and 19a-639. **Fee Required.**	
2. Enter $0 on "Total Fee Due" line (SECTION B) if application is required pursuant to Section 19a-638 only, otherwise go on to line 3 of this section.	
3. Enter $400 on "Total Fee Due" line (SECTION B) if application is for capital expenditure for major medical equipment, imaging equipment or linear accelerator exceeding $400,000 but less than or equal to $1,000,000	
4. Section 19a-639 fee calculation (applicable if section 19a-639 capital expenditure for major medical equipment, imaging equipment or linear accelerator exceeding $1,000,000 or other capital expenditure exceeding $1,000,000 is checked above OR if both 19a-638 and 19a-639 are checked):	
a. Base fee: _____	$ 1,000.00
b. Additional Fee: (Capital Expenditure Assessment)_____ (To calculate: Total requested Capital Expenditure including capitalized financing costs multiplied times .0005 and round to nearest dollar.) ($_____ x .0005)	$_____.00
c. Sum of base fee plus additional fee: (Lines A3a + A3b)_____	$_____.00
d. Enter the amount shown on line A3c. on "Total Fee Due" line (SECTION B).	
SECTION B TOTAL FEE DUE: _____	$_____.00

ATTACH HERE CERTIFIED OR CASHIER'S CHECK ONLY (Payable to: Treasurer, State of Connecticut)

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GENERAL AFFIDAVIT

Applicant: _____

Project Title: _____

I, _____, _____
(Name) (Position – CEO or CFO)

of _____ being duly sworn, depose and state that the (Facility Name) said facility complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

_____ _____
Signature Date

Subscribed and sworn to before me on_____

_____

Notary Public/Commissioner of Superior Court

My commission expires: _____